

TELEPHONE INTERVIEW FORM

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Clinic No.					
ID No.					
Form Type	T	I			

PART II: Sources and Data.

5. From whom does the information on this form derive (check all that apply)?

H. Other, specify ----- (1)

- B. Signature:**

4. Has this patient been located
(by contacting the patient,
a relative, a friend or a
health care provider)? ----- (1) (2)
Yes No

If the patient has not been located within the permissible time window, complete as much of this form as possible and send to the DCC.

Record the form type in the appropriate boxes in the upper right-hand corner of this page. Code as:

One month -----	01
Three months -----	02
Six months -----	03
Twelve months -----	04

- ## 6. Vital status

- A. Is this patient alive? -- (1) (2)
Yes No

This variable used to calculate status at follow up:
T1, T2, T3 and T4

If YES, proceed to Item 7.

- B. Place of death:

City _____ State _____

- C. Date of death:

_____-_____-_____
Month Day Year

Complete Death Form (PIOPED Form 35) and send to the DCC immediately. Complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

7. Hospitalization

- A. Has the patient been readmitted to any hospital since last PIOPED contact? --- (1) (2) (3)
Yes No Unk

If NO or UNK, proceed to Item 8.

B. Hospital Name _____

C. Address _____

City _____ State _____ Zip Code _____

Complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

8. Anticoagulation

- A. Has this patient been taking anti-coagulants since last PIOPED contact? ----- (1) (2) (3)
Yes No Unk

If NO or UNK, proceed to Item 9.

- B. Has the patient experienced any complications of anticoagulation since the last PIOPED contact? ----- (1) (2)
Yes No

If NO, proceed to Item 9.

1. Was this a bleeding complication? ----- (1) (2)
Yes No

If YES, proceed to Item 8B2.

- a. Specify complication

Proceed to Item 9.

8. (Continued)

2. Was this bleeding complication major by PIOPED criteria? --- (1) (2)
Yes No

If YES, complete Outcome Report Form (PIOPED Form 31) and send to the DCC as soon as possible.

9. Has the patient undergone any of the following since last contact:

- Yes No Unk
A. Lung scan ----- (1) (2) (3)
B. Leg venogram ----- (1) (2) (3)
C. Pulmonary angiogram ----- (1) (2) (3)
D. New anticoagulation ----- (1) (2) (3)

If YES to any of Items 9A, 9B, 9C, or 9D, complete Outcome Report Form (PIOPED Form 31) and send to DCC as soon as possible.

If NO or UNK to all of Items 9A, 9B, 9C, and 9D, proceed to Item 10.

- E. Name of (first) physician:

- F. Physician address:

City _____ State _____ Zip Code _____

- G. Telephone number:
() _____
Area Code

- H. Name of (second) physician:

- I. Physician address:

City _____ State _____ Zip Code _____

- J. Telephone number:
() _____
Area Code

ID No. _____

10. New diagnoses:

- A. Have any new diagnoses become known on this patient since last contact? _____ (1) (2) (3)
Yes No Unk

If NO or UNK, proceed to Item 11.

- B. Diagnoses _____

- C. ICD-9 code: 1. _____
2. _____
3. _____

11. Have any of the following symptoms newly occurred or, if previously present, increased in frequency or severity since last contact?

- | | Yes | No | Unk |
|-------------------------------|-----|-----|-----|
| A. Dyspnea _____ | (1) | (2) | (3) |
| B. Pleuritic chest pain _____ | (1) | (2) | (3) |
| C. Palpitations _____ | (1) | (2) | (3) |
| D. Hemoptysis _____ | (1) | (2) | (3) |
| E. Syncope _____ | (1) | (2) | (3) |

PART III: Coordination.

12. Checked for completeness and accuracy:

- A. Certification Number: _____

- B. Signature: _____

- C. Date: _____

Month - Day - Year

Retain a copy of this form for your files. Send the original to the PIOPED Data and Coordinating Center. Use PIOPED mailing labels:

Maryland Medical Research Institute
PIOPED Data and Coordinating Center
600 Wyndhurst Avenue
Baltimore, Maryland 21210

ID No. _____